Suite 6, Carter Building 44 Cooper St., Woodbury, NJ 08096
Phone - (856) 368-1008 press 3
Fax - (800) 507-8572

_____ _____
STUDENT NAME ADDRESS

_____ _____ _____
City State Zip Code

MANTOUX PPD TEST

As a student you are required by the state to submit ELNAP, a two-part PPD prior to attending our school. The second test must be administered no sooner than one week and no later than three after the first test is read. If you have already had a two-step PPD done for another school or employer, ELNAP, can accept a copy of both as long as they were within the past year, and the first and second steps within 1-3 weeks of each other.

If you have had a negative chest x-ray within the past year, you may use documentation of the x-ray instead of the two-step PPD

1st STEP
Date Administered_____
Administered By:_____ _____
Signature Name (please print)

2nd STEP
Date Administered_____
Administered By:_____ _____
Signature Name (please print)

Site_____ Lot #_____ Expiration_____

Date Read_____ Results_____

Read By_____ _____
Signature Name (please print)

If results are positive with either test, ELNAP requires a chest x-ray report that states the x-ray results are negative,

Student Name: _____

COMMUNICABLE DISEASE:
The above name student is free of communicable diseases
( ) Yes ( ) No

This person has been treated and there is no significant risk to others.
( ) Yes ( ) No

STUDENT PERFORMANCE	YES	NO
Lift		
Bend		
Ambulate		
Transfer Patients		
Does the Student Use		
Crutches		
Walker		
Cane		
Neck Brace		
Back Brace		
Back Support		

Is the student able to lift 40 lbs on a frequent basis?
( ) Yes ( ) No

Is the student able to stand and walk varied distances for at least (8) hours?
( ) Yes ( ) No

Is the student able to push and reach above his/her head, frequently?
( ) Yes ( ) No

Please note any restrictions, rehabilitations and specify precautions that must be taken in order for the student to work with Residents in a Long Term Care Facility. _____

_____

_____

THIS DOCUMENT MUST BE SIGNED BY A PHYSICIAN OR A NURSE PRACTITIONER

_____ _____

Print Examiners Name and Credentials Date

_____

Examiner's Signature

_____ _____

Address Telephone Number